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Office of Administrative Law Judges
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Issue Date: 27 April 2006

In the Matter of:

HAYMOND GEORGE ROSE,
Claimant

Case No.: 2003-BLA-5326

v.

SEWELL COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Ron Carson
Stone Mountain Health Services
St. Charles, Virginia
For the Claimant

Ashley Harman, Esq.
Jackson & Kelly, PLLC
Morgantown, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* The Act and implementing regulations, 20 CFR Parts 410, 718, 725, and 727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, Haymond G. Rose, alleges that he is totally disabled due to pneumoconiosis.

I conducted a hearing on this claim on August 11, 2004, in Beckley, West Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("Tr.") at 20-32. Director's Exhibits ("DX") 1-42, ALJ Exhibits ("ALJ") 1, Claimant's Exhibits ("CX") 1-7, and Employer's Exhibits ("EX") 1, 7, 11-12 were admitted into evidence without objection. Tr. at 7, 9, 13-17, & 19. Employer's Exhibits 2-6 and 8-10 were excluded because they exceeded the limitations for the submission of evidence contained in the regulations, and the Employer failed to show good cause for their admission. Tr. at 12-17. The record was held open after the hearing to allow the parties to submit additional evidence and argument. I hereby admit the following additional exhibits which have been submitted timely by the parties: CX 8 and EX 13-16. The Employer submitted a closing argument, and the record is now closed.

Post-hearing review of the record discloses that one of the Director's Exhibits should not have been admitted into evidence. DX 29, rebuttal of the Director's pulmonary function study by Dr. Zaldivar on behalf of the Employer, was admitted without objection. However, at the hearing, the Employer submitted another report rebutting that study, by Dr. Renn, EX 7. The Employer is entitled to submit only one report to rebut the Director's pulmonary function study. Twenty CFR § 725.414(a)(3)(ii). Admission of both DX 29 and EX 7 therefore exceeded the evidentiary limits. The Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties. *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-169 (2004). Moreover, the Employer identified EX 7, but not DX 29, as an exhibit on which it was relying in its Evidence Summary Chart. DX 29 is therefore stricken from evidence, but remains in the record in case of an appeal.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on August 22, 2001. DX 2. The claim was awarded by the District Director of the Office of Workers' Compensation Programs ("OWCP") on October 7, 2002. DX 34. The Employer appealed this decision and requested a formal hearing on October 14, 2002. DX 37. The case was referred to the Office of Administrative Law Judges for hearing on January 6, 2003. DX 40.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 CFR Parts 718 and 725 apply. Twenty CFR §§ 718.2 and 725.2 (2005). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. Twenty CFR §§ 718.1, 718.202, 718.203, and 718.204 (2005).

ISSUES

The issues contested by the Employer are:

1. Whether the claim was timely filed.

2. How long the Claimant worked as a miner.

3. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations.

4. Whether his pneumoconiosis arose out of coal mine employment.

5. Whether he is totally disabled.

6. Whether his disability is due to pneumoconiosis.

DX 40; Tr. 5-6. The Employer also reserved its right to challenge the statute and regulations. DX 40.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Rose testified that he was 60 years old at the time of the hearing. Tr. 20. He has a sixth-grade education. Tr. 20. He is divorced. Tr. at 6, 27.

He testified that he has worked in the coal mines for at least 12 years. Tr. 20. The Employer stipulated to his seven years of employment with Sewell Coal Company. Tr. 5-6. Mr. Rose testified that before he worked for Sewell, he worked two years for Peerless Eagle, and four years for Terry Salinger. Tr. at 26. At Sewell, he was supply man, which required lifting and carrying 50 pounds for 50 feet in an underground mine with a 48" coal seam. Tr. 21-23. He left mining in 1982 when he found out he had black lung during a physical given when he was called back after a mine shutdown. Tr. 24.

He first noticed he had breathing problems while he was working for Sewell. Dr. Ward put him on inhalers. Tr. 24-25. At the time of the hearing, he was being treated by Dr. Wentz. Four years before he had been on oxygen for six months after being in the hospital for congestive heart failure. Tr. 25. He used to smoke, but after being in the hospital he quit, only starting again when he went through his divorce. At the time of the hearing, he was taking a few puffs off two cigarettes per day. Tr. 26-27. He smoked as much as two packs a day when he was young, but said it was more like 10 cigarettes a day after that. He denied smoking as much as two or three packs a day at the time he was hospitalized. Tr. 27-29.

His last coal mine employment was in West Virginia. Tr. 26. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*).

Timeliness

Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Twenty CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. The claim in this case was filed in August 2001. At the hearing, Mr. Rose was asked, "[h]as any doctor ever told you that you were totally disabled because of Black Lung and that you would no longer be able to work because of that?" Tr. 30. Mr. Rose responded, "I've had doctors to tell me that I was totally disabled, that I wouldn't be able to work again," identifying Dr. Mark Wentz and Dr. Ray as the doctors who told him that. Tr. at 30-31. Dr. Wentz is his current physician, and his treatment notes are not in the record. Dr. Ray's notes are in the record. They indicate that he saw Mr. Rose once in 1996 and three times in 2000, but none of those visits related to his pulmonary condition. Mr. Rose said Dr. Ward told him in 1992 he had black lung "real bad," and that it would be hard for a man his age and condition to work; he then referenced his 15% state black lung award. Tr. at 31. A 15% award does not reflect total disability based on black lung alone. Mr. Rose's Social Security disability award in 2001 was based on multiple impairments, not just his lungs. DX 8. The earliest medical record in the file indicating total disability due to the condition of his lungs is the February 2002 report by Dr. Norma Mullins, who examined Mr. Rose on behalf of the Department of Labor, after he filed his claim. I find that the Employer has failed to rebut the presumption of timeliness.

Length of Employment

According to the employment histories the Claimant submitted to the Department of Labor and Social Security records, the Claimant began working in the mines in 1965. DX 4-6. He left the mines in 1982. DX 6. He testified that he worked in the mines for 12 years. The Employer stipulated to the time Mr. Rose was employed at Sewell, which was seven years. The record supports Mr. Rose's testimony of 12 years of coal mine employment. *See* DX 4-7. Therefore, I find that Mr. Rose had at least 12 years of coal mine employment.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case. X-ray interpretations designated by the parties in accordance with the limitations contained in 20 CFR § 725.414 (2005) appear in bold print.

The existence of pneumoconiosis may be established by chest x-rays classified as Category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. Twenty CFR

§ 718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH), or the registry of physicians' specialties maintained by the American Board of Medical Specialties.[1] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record, the NIOSH lists, or the Board of Medical Specialties. Qualifications of physicians are abbreviated as follows: A = NIOSH certified A reader; B = NIOSH certified B reader; BCR = Board-certified in Radiology. Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be Radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
07/06/78		DX 13 Gerlich B/BCR ILO Classification 0/1	
04/01/79			DX 13 Harron A/BCR "Lung fields are clear."
10/25/94	DX 13 Deardorff B/BCR "Consistent with pneumoconiosis; no significant change since previous [02/19/91] x-ray." Unclassified.		
03/01/95			DX 13 Shah B/BCR Pneumonic infiltrate. Chronic interstitial changes.

[1] NIOSH is the Federal Government Agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, Comprehensive List of NIOSH Approved A and B Readers, August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTML. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Information about physician board certifications appears on the web-site of the American Board of Medical Specialties, found at http://www.abms.org.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
10/28/97			DX 13 Iyengar BCR Lung fields clear.
10/29/97			DX 13 Iyengar BCR Normal chest.
03/12/98			DX 13 Shah B/BCR Cardiomegaly and COPD changes.
10/08/98			DX 13 Cruz A Lungs clear.
03/13/00			DX 13 Cruz A Lungs free of acute infiltrates. Borderline cardiomegaly.
06/06/00			DX 13 Thomas BCR COPD. Mild cardiomegaly.
02/18/02	**CX 4 Alexander B/BCR ILO Classification 1/1 DX 20 Patel B/BCR ILO Classification 1/1**	**DX 32 Wiot B/BCR**	DX 21 Gaziano B Read for quality only Film quality 2 (Acceptable)
08/12/02	**CX 8 Alexander B/BCR ILO Classification 1/1**	**EX 1 Willis B/BCR**	
06/05/02	**CX 3 Pathak[2] B/BCR ILO Classification 1/2**	**DX 33 Zaldivar B**	
12/19/03	**CX 1 Cappiello B/BCR ILO Classification 1/0 CX 2 Alexander B/BCR ILO Classification 1/2**	**EX 14 Wheeler B/BCR EX 15 Scott B/BCR**	

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the

[2] Board certified in the United Kingdom. CX 3. *See Hendrix v. Jim Walter Resources, Inc.*, BRB No. 99-1332 BLA, note 1 (Nov. 30, 2000) (unpub.).

flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one second (FEV_1), and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. Pulmonary function studies designated by the parties in their evidence summaries to be considered in accordance with the limitations contained in 20 CFR § 725.414 (2005) appear in bold print. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. Twenty CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	**Age/ Height[3]**	**FEV_1 Pre-/ Post**	**FVC Pre-/ Post**	**FEV_1/ FVC Pre-/ Post**	**MVV Pre-/ Post**	**Qualify?**	**Physician Impression**
DX 13 11/04/94 (illegible signature)	50/ 68"	2.39	3.50	68%		No	Mild obstruc-tion. No tracings. No effort noted. Not designated by any party.
DX 13 02/29/00 Ward	55/ 68"	1.65	2.32	71%		Yes	No effort noted (contains hand-written note "invalid ?effort" with illegible initials). Not designated.
DX 13 06/26/00 Khorshad[4]	56/ 70"	2.09 2.42	3.59 4.25	58% 57%		No No	Suggests obstructive disease. No tracings. No effort noted. Not designated.

[3] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the Miner from 68" to 70" I have taken the mid-point (69") in determining whether the studies qualify to show disability under the regulations.

[4] This report is marked received by the DDS [Disability Determination Services] of Charleston, West Virginia, from which I infer that it was obtained in connection with Mr. Rose's Social Security claim. I have not considered it as it is not established that it is a treatment record, and, in any event, it cannot be validated.

Ex. No. Date Physician	Age/ Height^3	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 18 02/18/02 Mullins	**57/ 70"**	**2.09 1.94**	**3.66 3.60**	**57% 54%**	**71**	**No Yes**	**Validated on 4/22/02 by Dr. Gaziano DX 19 (illegible signature compared to DX 21)** **Invalidated by Dr. Renn EX 7**
DX 33 06/05/02 Zaldivar	**58/ 69"**	**1.89 2.07**	**3.26 3.72**	**58% 56%**	**66 76**	**Yes No**	**Moderate irreversible obstruction. Air trapping by lung volume.**
EX 1 08/12/02 Crisalli	**58/ 69"**	**1.94 2.17**	**3.21 3.56**	**60% 61%**	**64**	**Yes No**	**Invalid. Post-bronchodilator study showed mild obstruc-tion. Severe air trapping and diffusion defect. No restriction.**
CX 6 12/30/03 Narayanan	**59/ 70"**	**1.76**	**3.12**	**56%**		**No**	**Severe obstruction.**
CX 5 04/14/04 Narayanan	**60/ 69"**	**1.69**	**2.77**	**61%**		**No**	**Moderate obstruction , low vital capacity, possibly from concomitant restrictive defect.**

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. Twenty CFR § 718.105(b) (2005).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 15	02/18/02	Mullins	48.4 41.9	54.5 54.5	Yes Yes	Mr. Rose was unable to reach target HR of 139; He became too tired. Validated on 4/9/04 by Dr. Gaziano DX 16 (illegible signature compared to DX 21)
DX 33	06/05/02	Zaldivar	43 42	54 61	Yes No	Exercise stopped due to shortness of breath. Hypoxemia at rest and with exercise
EX 1	08/12/02	Crisalli	47	58	Yes	Hypoxemia

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. Twenty CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories. Twenty CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner

from engaging in employment, *i.e.*, performing his usual coal mine work or comparable and gainful work. Twenty CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. Twenty CFR § 718.204(c)(2) (2005). The record contains the following medical opinions relating to this case.

Treatment Records and Records from the Claimant's Social Security Disability Claim

The Claimant submitted over 200 pages of records previously submitted to the Social Security Administration, DX 13, along with a favorable decision on Mr. Rose's application for Social Security Disability benefits, DX 8. The award of Social Security Disability benefits was based on findings of multiple medical problems including diabetes mellitus, high blood pressure, chronic obstructive pulmonary disease, and degenerative disc disease. Of the medical records, only those relevant to the claim for black lung benefits will be addressed here.

The medical records include various records of treatment at the Summersville Memorial Hospital from May 2, 1978, to September 27, 2000. DX 13. The following table summarizes Mr. Rose's treatment at the hospital relating to problems with his lungs. X-ray reports associated with treatment at Summersville are included in the table above.

Date	**Type of Report**	**Diagnoses (cardiopulmonary only) and pulmonary findings**
May 2, 1978	Outpatient record	Bronchitis. Lungs were clear.
February 4, 1981	Outpatient record	Upper respiratory infection.
October 10, 1980	Outpatient record	Acute bronchitis. Scattered expiratory rhonchi reduced after coughing.
February 2, 1994	Emergency Room Notes	Bronchitis secondary to the flu.
October 28 - 29, 1997	Discharge/Transfer Summary	Chest pain, probable unstable angina; hypertension; pneumoconiosis. Noted a past medical history of pneumoconiosis and a chest examination which demonstrated the lungs "have distant breath sounds and at this point are clear, although when [another doctor] listened to him earlier in the evening, he had some rhonchi but no rales."
March 12, 1998	Emergency Room Notes	Acute bronchitis.
March 13, 2000	Emergency Room Notes	Acute bronchitis.
June 6, 2000	Emergency Room Notes	Acute bronchitis.

Mr. Rose's treatment records from Dr. Michael Ward from 1992 to 2000 are also included in the record. DX 13. Dr. Ward's qualifications are not in the file, and I could not determine them from the American Board of Medical Specialties' website. A problem list noted

that Mr. Rose smoked greater than a pack of cigarettes per day since 1960, and that he received a 15% state occupational pneumoconiosis award after 18 years of underground mining, having left the mines in 1992.[5] This portion of the record contains many illegible handwritten progress notes; the only material legible notations, on several of the progress notes, appear to be COPD [chronic obstructive pulmonary disease], SOB [shortness of breath], PFT [pulmonary function test], bronchitis, and references to the fact that Mr. Rose was still smoking. On June 10, 1994, Mr. Rose was evaluated at a sleep center by Dr. Zaldivar. Dr. Zaldivar reported to Dr. Ward that Mr. Rose "has obstructive apneas and hypopneas associated with bradycardia/tachycardia and low oxygen saturation of 76% during REM sleep." He prescribed treatment with Nasal CPAP. These records also include pulmonary function tests from November 4, 1994, to February 29, 2000, and an x-ray report dated October 21, 1994, the results of which appear on the tables above.

Dr. John Ray's notes dated January 25, 1996, and August 1, October 2, and November 9, 2000, state that Mr. Rose's lungs were clear. None of the visits were occasioned by problems with his lungs. DX 13. Dr. Ray's qualifications are not in the record, and could not be determined from the American Board of Medical Specialties' website.

Dr. Joseph Snead, an Orthopedic Surgeon, performed a disability evaluation of Mr. Rose on December 6, 2000, at the request of his counsel. Dr. Snead prepared a report dated January 1, 2001. DX 13. Dr. Snead reviewed Mr. Rose's medical records as part of his examination. He noted that Mr. Rose was undergoing treatment for pneumoconiosis. Dr. Snead noted that an "auscultation of his lungs revealed clear breath sounds, but they were distant." Dr. Snead diagnosed Mr. Rose with diabetes mellitus, chronic obstructive pulmonary disease ("manifested by pulmonary function studies and chest x-rays"), and pneumoconiosis ("manifested by chest x-ray"), history of high blood pressure, and degenerative disc disease. Dr. Snead opined that Mr. Rose "is totally and permanently disabled for all gainful employment that he would be qualified for by reason of previous work experience or education." He did not attribute the disability to any single medical diagnosis, but suggested that Mr. Rose would be limited to sedentary work. Although submitted along with treatment records, I conclude that this was not a treatment record, but rather, an evaluation performed in connection with Mr. Rose's application for Social Security disability benefits. The Claimant designated another report, by Family Nurse Practitioner Brooks, CX 7, as the only medical report in support of his position on the Evidence Summary Form. Nonetheless, as the exhibit was admitted without objection, and the Claimant is entitled to submit two medical reports, s*ee* 20 CFR § 725.414(a)(2)(i), I have weighed Dr. Snead's report along with the other medical reports.

Robert L. William, M.A., completed a vocational report dated December 9, 2000, which was submitted along with Mr. Rose's medical records. DX 13. This, too, appears to have been generated in conjunction with Mr. Williams' Social Security claim. Mr. Williams noted that Mr. Rose said he had been unable to work since January 2000 because of his back condition and difficulty breathing. Mr. Rose reported symptoms of shortness of breath, difficulty in breathing while walking on level ground, and increased shortness of breath if walking up an incline.

[5] In response to an inquiry from the Department of Labor, a representative of the West Virginia Coal Workers' Pneumoconiosis Fund indicated that the award was later annulled. DX 9. The records from the state proceedings are not in the file, so I cannot determine the basis for either the award, or the later annulment. The reference to the year 1992 as the time Mr. Rose left the mines may be a clerical error, as his coal mine employment occurred between 1966 and 1982.

Additionally, Mr. Williams noted that Mr. Rose reported a 15% permanent disability partial disability for black lung disease. Mr. Williams reported that Mr. Rose has occupational pneumoconiosis as diagnosed by Dr. Wantz[6] and in several x-ray reports. Mr. Williams was unable to determine the exact extent of Mr. Rose's limitations, but assumed him unable to perform light, medium, or heavy work. Mr. Williams administered some vocational testing. Based on his age, education, prior work experience, and physical limitations, Mr. Williams concluded that Mr. Rose is disabled for employment in the labor market. As Mr. Williams is not a medical practitioner, I have not treated this as a medical report. The medical information reported to Mr. Williams is consistent with the medical records.

L. Andrew Steward, Ph.D., Licensed Psychologist, completed a psychological evaluation of Mr. Rose and prepared a report dated December 15, 2000. A psychiatric review technique form accompanied the report. DX 13. It appears that this report, too, was prepared for Mr. Rose's Social Security claim. Dr. Steward noted that Mr. Rose stated he suffers from black lung and shortness of breath. Dr. Steward noted that Mr. Rose's medical records demonstrated that Mr. Rose's medical problems included chronic obstructive pulmonary disease and pneumoconiosis. Like the vocational report, the information concerning Mr. Rose's physical condition referenced in this report is consistent with the other medical records. The psychological report does not otherwise shed any light on Mr. Rose's pulmonary condition for purposes of the Black Lung claim.

Opinions Given in Connection with the Black Lung Claim

Dr. Norma J. Mullins examined Mr. Rose on behalf of the Department of Labor on February 18, 2002. DX 14. According to the American Board of Medical Specialties' website, she is Board-certified in Internal Medicine and Pulmonary Disease. She took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. She reported that Mr. Rose worked in the mines for 12 years. She reported a smoking history of one pack per day (currently down to two cigarettes per day) since 1962. The chest examination was normal. Dr. Mullins relied on Dr. Patel's reading of the x-ray as showing pneumoconiosis. *See* DX 20. The pulmonary function test showed moderate impairment. The arterial blood gas study showed hypoxemia at rest and with exercise. Dr. Mullins diagnosed coal workers' pneumoconiosis (based on x-ray and caused by coal dust exposure), chronic obstructive pulmonary disease (due to coal workers' pneumoconiosis and smoking), and heart disease (due to "family history, HTN [hypertension], DM [diabetes mellitus] and smoking"). Dr. Mullins found that Mr. Rose had a moderate impairment which she attributed equally to coal workers' pneumoconiosis and other causes. Dr. Mullins said Mr. Rose had a moderate impairment secondary to lung and heart disease which would impair performance of his last job. She went on to refer to the arterial blood gas tables found in 20 CFR Part 718, stating that by the regulations, he would be considered 100% disabled. Dr. Mullins attributed 50% of Mr. Rose's impairment to CWP [coal workers' pneumoconiosis] and 50% to other causes.

Dr. George Zaldivar examined Mr. Rose at the request of the Employer on June 5, 2002. DX 33. Dr. Zaldivar is Board-certified in Internal Medicine and Pulmonary Disease, and a

[6] This appears to be a reference to Dr. Susie Wantz, one of the doctors who attended Mr. Rose at Summersville when he was admitted with chest pain in 1997. She listed pneumoconiosis as one of her diagnoses.

B reader. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. Additionally, Dr. Zaldivar reviewed other medical data concerning Mr. Rose. He reported that Mr. Rose worked in the mines for 18 years. He reported that Mr. Rose said he "began smoking at the age of 35, smoking until one year ago. He [Mr. Rose] said he used to smoke half a pack of cigarettes per day." The chest examination was clear to auscultation. Dr. Zaldivar read the x-ray as being completely negative. The pulmonary function test showed moderate irreversible airway obstruction. The arterial blood gas study showed hypoxemia at rest and with exercise. Dr. Zaldivar diagnosed a severe pulmonary impairment as a result of his smoking habit which has produced severe emphysema. Based upon his examination, Dr. Zaldivar concluded that Mr. Rose was not suffering from coal worker's pneumoconiosis. Dr. Zaldivar found that Mr. Rose had a severe impairment in function based on his lungs, and that he does not retain the respiratory capacity to perform his last job in the mines or other job of similar exertional requirements. As to the cause of the impairment, Dr. Zaldivar opined, "All of the pulmonary impairment present is the result of his smoking habit. There is no pulmonary impairment present that could be attributed to his work in the coal mines."

In a deposition taken on June 23, 2003, Dr. Zaldivar testified regarding his examination of Mr. Rose. EX 11. Dr. Zaldivar reiterated the opinion he gave at the time of the examination. He said the smoking history Mr. Rose gave him was inaccurate, because the carbon monoxide level in his blood was equivalent to smoking two to three packs of cigarettes per day. Dr. Zaldivar confirmed that it was he who had diagnosed Mr. Rose with sleep apnea in 1994. Dr. Zaldivar testified that "one has to be careful when reviewing doctors' records and hospital records and a diagnosis of either COPD or pneumoconiosis is entered because often times there's no independent investigation of those conditions by the physician who's writing the diagnosis … such diagnosis becomes simply hearsay. And it's entered into the record as if it were factual information." EX 11 at 25. Dr. Zaldivar attributed Mr. Rose's breathing problems to emphysema from smoking, and his weight, including sleep apnea and general deconditioning. Asked whether coal dust exposure could have contributed to the emphysema, Dr. Zaldivar said,

> No. In his case, it is expected for emphysema to occur given the smoking habit. And as I said the chest x-ray, although it's not the only diagnostic test, shows that the amount of dust retained within the lungs is very low, if any at all.
>
> Therefore, there is no reaction to the dust that could damage the airway. So we have only one agent which is causing the problem, and that is the smoking habit….

Dr. Zaldivar said that Mr. Rose is disabled from a pulmonary standpoint because of his hypoxemia, but none of the disability is the result of pneumoconiosis. Asked to comment on Dr. Mullins' attribution of hypoxia to coal workers' pneumoconiosis and congestive heart failure, Dr. Zaldivar noted that her examination did not reveal congestive heart failure, and he could not say why she thought either condition had anything to do with Mr. Rose's condition. He also noted that he had much more extensive information available to him than did Dr. Mullins. Dr. Zaldivar said there was nothing pointing to coal workers' pneumoconiosis as a contributing factor to Mr. Rose's chronic obstructive pulmonary disease, concluding, "[i]ndividuals who smoke as much as he does over such a long period of time are expected to

have the kind of breathing capacity that he is exhibiting at this time. So the smoking habit alone explains everything." EX 11 at 30.

Dr. Robert Crisalli examined Mr. Rose on behalf of the Employer on August 12, 2002. EX 1. Dr. Crisalli is Board-certified in Internal Medicine and Pulmonary Disease. He took occupational, social, family, and medical histories, and conducted a physical examination, chest x-ray, blood gas studies, and pulmonary function testing. He reported that Mr. Rose worked in the mines for 22 years. He reported a smoking history of one pack per day for 30 years. At the time of the examination, Mr. Rose was on home oxygen and was using nebulizer therapy and inhalers. The chest examination was normal. Dr. Willis, a B reader, read the x-ray ordered by Dr. Crisalli as completely negative. Dr. Crisalli opined that the pulmonary function test, which was invalid, "at worst" showed mild obstruction. Additionally, Dr. Crisalli noted that due to variable performance by Mr. Rose during the pulmonary function studies, the data generated is invalid. The arterial resting blood gas study revealed hypoxemia and carbon dioxide retention, "all of which are consistent with the diagnosis of emphysema." Additionally, Dr. Crisalli reviewed Mr. Rose's medical data, which included x-rays, medical reports, and treatment records. Based upon this, Dr. Crisalli concluded that Mr. Rose was not suffering from coal worker's pneumoconiosis. In his opinion, Mr. Rose was suffering from severe pulmonary impairment related to Mr. Rose's severe emphysema "which is secondary to his very heavy smoking history." The pulmonary function and blood gas studies were more consistent with emphysema than with pneumoconiosis. Dr. Crisalli found that Mr. Rose does not retain the respiratory capacity to perform his last job in the mines or a job requiring similar effort outside of the mine. Dr. Crisalli opined that none of these impairments or disabilities is "secondary to coal dust exposure or to coal workers' pneumoconiosis."

In a deposition taken on September 13, 2004, Dr. Crisalli testified regarding his examination of Mr. Rose. EX 13. Dr. Crisalli reiterated the opinion he gave at the time of the examination. Dr. Crisalli estimated that he had seen about 10,000 coal miners in his 27 years of practice treating coal miners in West Virginia. Asked about his understanding of the definition of coal workers' pneumoconiosis under the Federal Black Lung program, he said:

> My understanding of the definition of coal workers' pneumoconiosis is that it consists of coal workers' pneumoconiosis itself or any disease in which the coal dust exposure has aggravated that particular disease or made the patient worse as a result of that exposure.
>
> So if someone had some other lung disease unrelated to coal dust exposure but the coal dust actually made that disease worse, then that would also be counted as coal workers' pneumoconiosis.
>
> I think chronic bronchitis is a cause of coal workers' pneumoconiosis. Obstructive lung disease that can be attributed to the coal dust exposure would also be coal workers' pneumoconiosis.
>
> Coal workers' pneumoconiosis can occur in the absence of radiographic abnormalities indicating changes of coal workers' pneumoconiosis.

DX 13 at 6-7. He went on to state that both simple and complicated pneumoconiosis can cause a totally disabling impairment, or very little impairment. In Mr. Rose's case, he said Mr. Rose had enough exposure to coal dust to develop dust-induced disease in a susceptible individual, but a history of exposure alone is not sufficient to make the diagnosis. Mr. Rose admitted to a 30 pack-year smoking history; Dr. Crisalli said a 15 pack-year history would be sufficient to develop smoking-related disease. He said Mr. Rose's carboxyhemoglobin level would correlate with smoking at least a pack a day of cigarettes, as opposed to the one or two cigarettes a day he said he was smoking. Dr. Crisalli attributed Mr. Rose's current symptoms to continued heavy smoking. He said the spirometry from his examination was invalid, but based on the post-bronchodilator FVC, Mr. Rose had only a mild obstruction, which Dr. Crisalli attributed to smoking-induced emphysema. He attributed Mr. Rose's hypoxemia to emphysema and obstructive sleep apnea, which causes changes in the blood vessels in the lungs which may not be reversible with use of a CPAP machine. He reiterated his opinion that Mr. Rose is totally disabled from a respiratory standpoint, but said that even if he were found to have simple pneumoconiosis, his obstructive impairment was mild, and he had no restrictive impairment based on his lung volumes. Thus he concluded that Mr. Rose was not disabled due to pneumoconiosis.

Kellie Brooks, Family Nurse Practitioner, examined Mr. Rose on June 14, 2004. Ms. Brooks took Mr. Rose's medical, individual, work, and social histories. CX 7. Mr. Rose was noted as smoking two cigarettes per day since age 16, with 18 years of coal mine employment. His chest examination was abnormal, with hyperresonance and diminished breath sounds with scattered rhonchi. Ms. Brooks assessed Mr. Rose with coal workers' pneumoconiosis and chronic obstruction pulmonary disease. The Claimant designated this report in his Evidence Summary Form as a medical report on which he relies to establish his right to black lung benefits.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical' pneumoconiosis and statutory, or 'legal' pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine

employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Twenty CFR § 718.201 (2005). In this case, Mr. Rose's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Ibid*.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

Twenty CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on: (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982), or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or, (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Rose has had a lung biopsy and, of course, no autopsy has been performed. None of the presumptions apply because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Rose has less than 15 years of work in coal mines and filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether the Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The record contains interpretations of 10 x-rays taken during treatment. Only two of those readings, one taken in 1978 classified 0/1, and one taken in 1994, characterized as "consistent with pneumoconiosis," but unclassified, mentioned the presence of pneumoconiosis. Others were read as clear (in 1979, 1997, 1998, and 2000), while still others were read as showing interstitial changes or COPD (in 1995, 1998, and 2000). None have been classified with a profusion of 1/0 or greater as required by the regulations, so the treatment x-rays cannot be used to establish the existence of pneumoconiosis.

All four x-rays read in connection with the claim for black lung benefits have been read as both positive and negative. For cases with conflicting x-ray evidence, the regulations specifically provide,

> … where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

Twenty CFR § 718.202(a)(1) (2005); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991). Readers who are Board-certified Radiologists and/or B readers are classified as the most qualified. The qualifications of a certified Radiologist are at least comparable, if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A Judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52.

The February 18, 2002, x-ray was read as positive by two dually qualified physicians and negative by one dually qualified physician. As there are more positive readings, I find that the x-ray is positive for the existence of pneumoconiosis.

The August 12, 2002, x-ray was read as positive by one dually qualified physician and negative by one dually qualified physician. As the equally qualified readers found pneumoconiosis to be both present and absent, I find that the readings of this x-ray are in equipoise as to the existence of pneumoconiosis.

The June 5, 2002, x-ray was read positive by one dually qualified physician and negative by one B reader. Giving greater weight to the reading by the dually qualified reader, I find this x-ray to be positive for pneumoconiosis.

The December 19, 2003, x-ray was read as positive by two dually qualified physicians, and negative by two dually qualified physicians. Thus, I find that the x-ray is in equipoise.

As I have found that two of the x-rays interpreted for pneumoconiosis were positive and that two were inconclusive, I conclude that the x-ray evidence weighs in favor of a finding of pneumoconiosis.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the Judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the Judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984).

None of the Claimant's treating physicians have provided an opinion on whether he has pneumoconiosis. Although several of the records which are in evidence refer to treatment for pneumoconiosis, the actual treatment records from Summersville Hospital, Dr. Ward, and Dr. Ray reflect treatment for bronchitis and chronic obstructive pulmonary disease without reference to pneumoconiosis. Nonetheless, as noted above, chronic obstructive pulmonary disease can constitute legal pneumoconiosis.

The medical opinions addressing whether Mr. Rose has pneumoconiosis are split. Dr. Snead and Dr. Mullins have both diagnosed pneumoconiosis based on x-ray evidence. Dr. Mullins also diagnosed chronic obstructive pulmonary disease caused by smoking and pneumoconiosis. Dr. Zaldivar and Dr. Crisalli have disagreed with the diagnosis of clinical diagnosis, in part because they have credited the negative x-ray readings over the positive ones. Both reject the proposition that exposure to coal dust contributed to Mr. Rose's chronic obstructive pulmonary disease or emphysema. Nurse Brooks also diagnosed pneumoconiosis, but I give her opinion little weight as I cannot determine the basis for it, she recites an erroneous smoking history, and she has substantially lesser qualifications than any of the doctors. I find that opinions by Drs. Snead, Mullins, Zaldivar, and Crisalli are all documented and reasoned. Each had the opportunity to take histories from Mr. Rose, examine him, and administer objective tests. Drs. Mullins, Zaldivar, and Crisalli are all qualified Pulmonologists. Dr. Snead is an Orthopedist, and I give his opinion on the existence of pneumoconiosis less weight than the others' because the Pulmonary Specialists are better qualified to evaluate the Claimant's pulmonary condition. Also, Dr. Snead did not identify which x-ray interpretations he considered when he diagnosed pneumoconiosis based on x-ray.

Considering the opinions of the Pulmonologists, turning first to the question of clinical diagnosis, I credit Dr. Mullins' positive diagnosis in part because it is consistent with the weight of the x-ray evidence. As noted above, however, Dr. Mullins diagnosed both clinical and legal pneumoconiosis caused by coal dust exposure and smoking. Drs. Zaldivar and Crisalli, on the other hand, diagnosed only smoking-induced chronic obstructive pulmonary disease or emphysema. At the outset, I note that Mr. Rose appears to have minimized his smoking history, admitting to two packs a day in his younger years, but only a few puffs off two cigarettes a day

since his hospitalization for congestive heart failure a few years before the hearing. The high carboxyhemoglobin values measured in his blood by Drs. Zaldivar and Crisalli, however, document that he was still smoking at least two packs a day at the time of their examinations. Thus, their conclusion that Mr. Rose continued to be a heavy smoker is supported by the objective evidence. However, the question remains whether their total exclusion of coal dust exposure as a contributing cause to the Claimant's chronic obstructive pulmonary disease should be credited.

In explaining the reasons for the definition of pneumoconiosis in the current regulations, including both clinical and legal pneumoconiosis, the Department of Labor stated the following in the commentary that accompanied the final rules found at 65 Fed. Reg. 79920, *et seq.* (2000):

> The term 'chronic obstructive pulmonary disease' (COPD) includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema and asthma. Airflow limitation and shortness of breath are features of COPD, and lung function testing is used to establish its presence. Clinical studies, pathological findings, and scientific evidence regarding the cellular mechanisms of lung injury link, in a substantial way, coal mine dust exposure to pulmonary impairment and chronic obstructive lung disease. In discharging its congressionally mandated duty to recommend a permissible exposure limit for coal mine dust, NIOSH conducted a comprehensive review of the available medical and scientific evidence addressing the impact of coal mine dust exposure on coal miners. … NIOSH concluded that '[i]n addition to the risk of simple CWP and PMF [progressive massive fibrosis], epidemiological studies have shown that coal miners have an increased risk of developing COPD.'

Sixty-five Fed. Reg. at 79938 (citation omitted). As for miners who smoke, the Department of Labor concluded that "[e]ven in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. The risk is additive with cigarette smoking." Sixty-five Fed. Reg. at 79940. The Department of Labor also cited to various studies which "support the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms.… [A]lthough many of the studies evaluating mechanisms of pathogenesis of coal mine dust exposure concentrate on the development of fibrosis, there is considerable basic scientific data linking coal mine dust to the development of obstructive airways disease." Sixty-five Fed. Reg. at 79943.

A close examination of their opinions reveals that both Dr. Zaldivar and Dr. Crisalli based their opinions that pneumoconiosis did not contribute to the Claimant's emphysema on their conclusions that he does not have clinical pneumoconiosis. Dr. Zaldivar rejected coal dust exposure as a cause of obstructive disease in Mr. Rose because the x-ray showed the amount of dust retained in his lungs was low. Dr. Zaldivar concluded that in that circumstances, coal dust could not have damaged the airway. He simply ignored the premise that coal dust can contribute to obstructive disease, even without positive x-ray evidence. His opinion is undermined further by the fact that he viewed the x-ray evidence to be negative, while I have found it to be positive. Although Dr. Crisalli gave lip service to the definition of legal pneumoconiosis in his deposition, his report, and his testimony, he treated emphysema as a diagnosis distinct from pneumoconiosis, and never offered any convincing explanation for the reason he excluded exposure to coal dust as a contributory cause to the emphysema, which he acknowledged existed. In addition, he, too,

found the x-ray evidence to be negative. For these reasons, I give greater weight to the diagnosis of clinical and legal pneumoconiosis by Dr. Mullins, as her report is consistent with the premises underlying the regulations and supported by the positive x-ray evidence.

I find that the Claimant has borne his burden to establish that he has clinical and legal pneumoconiosis based on the x-ray evidence and the report of Dr. Mullins, further supported by the report of Dr. Snead, as well as treatment records showing treatment for chronic obstructive pulmonary disease.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for 10 or more years. Thirty U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2005). Mr. Rose was employed as a miner for at least 12 years and, therefore, is entitled to the presumption. There is no evidence in the record to rebut the presumption. I find that Mr. Rose's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and, (5) lay testimony. Twenty CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. Twenty CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that Mr. Rose suffers from complicated pneumoconiosis or cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies, and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. Twenty CFR § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

The record contains the results of eight pulmonary function studies. However, three of the studies (from November 1994, February 2000, and June 2000) cannot be validated. Thus none of the three can be considered for this reason, and the last cannot be considered for the additional reason that it was not administered as part of Mr. Rose's treatment, and both the Claimant and the Employer designated two other pulmonary function studies to be considered in support of their positions, rendering it excessive under the rules. Of the tests designated by the parties to be relied upon, the results were inconsistent; at least one (the test given in February 2002) was of questionable validity; and the two most recent did not result in qualifying values. I,

therefore, find that the Claimant has failed to establish disability based on the pulmonary function studies.

The results of the arterial blood gas studies, on the other hand, were much more consistent. All except the exercise study performed on June 5, 2002, produced qualifying results, and that test was very close, within one point of qualifying. Therefore, I find that Mr. Rose has established disability based on the arterial blood gas studies. Moreover, these results are not inconsistent with the pulmonary function tests, which measure a different aspect of lung function.

In addition, the medical opinions also support a finding of total pulmonary or respiratory disability. Dr. Snead, Dr. Mullins, Dr. Zaldivar, and Dr. Crisalli, all opined that Mr. Rose is disabled. Dr. Snead's opinion was based on a combination of impairments, including his lungs. That is insufficient to constitute disability within the meaning of the statute and regulations. However, all of the Pulmonologists agreed that Mr. Rose has a total respiratory disability. Dr. Mullins' finding that Mr. Rose was totally disabled by his lungs was not explicit, as she referred to both his lungs and heart; however, she also referred to the standard for disability found in the regulations based on the arterial blood gas study. I infer from this that Dr. Mullins found Mr. Rose to be totally disabled by the impairment to his lungs. Both Drs. Zaldivar and Crisalli also found that Mr. Rose did not retain the respiratory capacity to return to his last job in the mines or similar work outside the mines. Therefore, I also find that Mr. Rose has established disability based on the medical opinions.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis was a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. Twenty CFR § 718.204(c) (2005); *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 610 (6th Cir. 2001).

The Benefits Review Board has held that § 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("[t]hus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …"). The Fourth Circuit has long required that pneumoconiosis be a "contributing cause" of the miner's disability. *Hobbs v. Clinchfield Coal Co*., 917 F.2d 790, 791-792 (4th Cir. 1990). In *Toler v. Eastern Associated Coal Co*., 43 F.3d 109 (4th Cir. 1995), the Court found it "difficult to understand" how an Administrative Law Judge (ALJ), who finds that the miner has established the existence of pneumoconiosis, could also find that his disability is not due to pneumoconiosis on the strength of the medical opinions of doctors who had concluded that the miner did not have pneumoconiosis. The Court noted that there was no case law directly on point and stated that it need not decide whether such opinions are "wholly lacking in probative value." However, the Court went on to hold:

> Clearly though, such opinions can carry little weight. At the very least, an ALJ who has found (or has assumed arguendo) that a claimant suffers from pneumoconiosis and has a total pulmonary disability may not credit a medical opinion that the former did not cause the latter unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates in the causal chain.

Forty-three F.3d at 116. *See also, Scott v. Mason Coal Company*, 289 F.3d 263, 269-270 (4th Cir. 2002).

Dr. Mullins attributed 50% of Mr. Rose's impairment to coal workers' pneumoconiosis. I give little weight to Drs. Zaldivar's and Crisalli's contrary opinions on this issue, because they did not diagnose pneumoconiosis. I can find no specific and persuasive reasons for concluding that their opinions on the question of causation did not rest on their finding that Mr. Rose does not have pneumoconiosis. I, therefore, credit Dr. Mullins' opinion, and find that the Claimant has borne his burden to establish that pneumoconiosis contributed to his disability.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Medical evidence of total disability does not establish the date of entitlement; rather, it shows that a claimant became disabled at some earlier date. *Owens v. Jewell Smokeless Coal Corp.*, 14 BLR 1-47, 1-50 (1990). Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed, unless the evidence establishes that the miner was not totally disabled due to pneumoconiosis at any subsequent time. Twenty CFR § 725.503(b) (2005); *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006), slip op. at 17.

The Claimant filed his claim for benefits in August 2001. When he was examined by Dr. Mullins in February 2002, he was already totally disabled. I find that the Claimant is entitled to benefits commencing in August 2001, the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that he is totally disabled due to pneumoconiosis and is, therefore, entitled to benefits under the Act.

ORDER

The claim for benefits filed by Haymond George Rose on August 22, 2001, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the Administrative Law Judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the Administrative Law Judge's decision is filed with the District Director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, D.C., 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, D.C., 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the Administrative Law Judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).